Commentary

Evaluation of the National Centers of Excellence in Women's Health: Sustaining the Promise

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As the field of women's health has developed over the past decades, so too has attention to health care delivery, and how to meet the needs of women. In the 1960s, "women's health centers" began to develop, designed by and for women.[1] A 1994 Commonwealth Fund supported study of women's health centers showed that many of the earlier models of community-based, reproductive health–focused, women's health centers had given way by the late 1980s to hospital-based models. These newer models were often an attempt to respond to the need for an increasingly complex set of services across a woman's full life span.[1] In 1996, the Department of Health and Human Services, through its newly established Office on Women's Health (OWH), identified the designation of national centers of excellence in women's health as a potential way of expanding and improving upon these models of care delivery. The federal centers of excellence had to meet a daunting set of requirements—clinical, research, coordination with local communities, public and professional education, and leadership development as well as evaluation plans. Impressively, between 1996 and 1998, OWH established centers of excellence at 18 academic health centers around the country, including six with a greater emphasis on health care for minority women.[2] By 2000, the OWH had provided 12 million dollars in support for these centers.[3]

Two papers in this issue, by Anderson et al.[4] and Goodman et al.,[5] provide substantial evidence in support of the models and accomplishments of the National Centers of Excellence in Women's Health (CoEs). The papers focus on the 15 centers in operation in 2001. Therefore, the centers have been in operation for 3 to 5 years, perhaps too brief a period to expect comprehensive outcomes, but a reasonable length of time to gain some idea of what has happened.

A primary tenet of the CoEs was to develop models of health care delivery for women that would provide " . . . an integrated 'one stop shopping' model for the delivery of clinical health care services to women with an emphasis on

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prevention and early detection."[6] The importance of the focus on this integrated model of care drew on the work in women's health care in preceding years which highlighted the complexity of organizing care: lack of coordination, women's reliance on more than one physician or site of care, and, even with multiple providers, certain types of care, such as mental health services, remained overlooked or difficult to receive when needed. These shortcomings were reflected in women's ratings of satisfaction with their care, as well as in measures of health care utilization.

The Anderson paper focuses on achievements of the CoEs in improving the quality of care to women. This paper utilizes some creative local and national benchmarking approaches to assess whether these quality of care issues were indeed improved upon at the CoE. Overall, quality, as measured by receipt of appropriate preventive care and satisfaction with care, was higher among women who were patients of the CoEs, compared with national and local samples of women. Women patients of CoEs received more preventive screening tests such as mammography, and more counseling, particularly on sensitive topics such as domestic violence and prevention of sexually transmitted diseases. CoEs also appear to have fostered better primary care relationships with their patients, as evidenced by coordination and continuity of care. These findings are consistent with the clinical goals of the program to provide coordinated, integrated, state-of-the-art care. The fact that the CoE population of women was more diverse than the comparisons also offers some promise with respect to efforts to eliminate racial and ethnic disparities in health.

What we cannot discern from this analysis, as noted by the authors, is whether there are specific (replicable) aspects of the CoE model, which led to the higher quality performance, or whether the entire model as implemented is necessary. Some documentation of whether, and how, linking medical training and research with care delivery improved that delivery would be important in the path to sustaining and replicating these models at other academic health centers—and nonacademic health center hospitals. Comparing the experiences of women patients at the same academic health center who did not use the CoE physicians would also be important in fine tuning the evaluation, and identifying where the added value of the CoE model occurs. Despite these limitations, the findings certainly show an improvement in primary and preventive care received through the CoE compared with the care received by the general population of women.

The Goodman paper reports on an assessment of organizational issues related to the establishment of the CoEs at the various academic health centers. This paper provides impressive support for the notion of designating centers of excellence in a field—legitimizing the field, increasing internal support for women's health, bringing people and departments together, leveraging internal and external resources. These positive movements facilitated the development of additional programs in medical education, community health, and leadership development, all linked to the women's health center. However, this qualitative assessment also provides sobering findings with respect to the future. Some key informant interviews raised concerns that women's health is now separate and "ghettoized," that collaboration was time-consuming and without compensation, and that the centers were not profitable in a difficult health care economy. There was a view that the centers would require significant ongoing resources from internal and external sources, and there was a concern that these resources were not there. Sustainability, therefore, is a critical issue.

Indeed, these are hard times for women's health centers. A recent news article in New York City reported on the closing of one major hospital-based women's health center and reported that others have yet to reach profitable

stage.[7] More than ever, these centers will require institutional commitment, support of hospital leadership—and an ability to show evidence of their value, in order to survive. A somewhat more optimistic paper from 2001 identified examples of how CoEs had leveraged their initial funds, and stressed the importance of leadership in identifying opportunities to leverage initial funds and use the prestige of the CoE designation.[8] This leveraging included support from corporations, private donors, foundations, and the academic health center itself.

These authors also stressed the importance of showing the value added in multiple ways, particularly when it is not evident through patient care revenue.[8] One of the hypotheses behind women's health centers—and, indeed, one of the potential criticisms—was that hospitals were creating these centers solely as marketing tools to attract women, and their families, to receive care at that hospital. Neither of the current evaluations addressed or documented whether the CoEs did in fact facilitate such a draw. If it is occurring, however, this is information the academic health center sponsors need to know. At least equally important, however, should be the ability to feedback to the sponsoring institution data on quality of care provided. As health care institutions increase efforts to improve every aspect of quality of care delivered—including safety, coordination, and information for patients—women's health centers would probably benefit from greater attention to assessing and reporting their performance. The Anderson paper suggests there is more to be mined from these centers with respect to quality performance.

Coincident with financial pressure on women's health centers is the growing need for the work of these centers. Recent news in women's health provides some clear evidence for the importance of centers such as these. With respect to patient care, women are faced with increasingly complex decisions on issues such as care at menopause, hormone replacement therapy, breast cancer screening, effect of antidepressants, and dietary recommendations. These are issues that require knowledgeable health care professionals, with the time and ability to guide women, and provide them with information they need to make good decisions. Other preventive services, such as colon cancer screening, still lag far behind desired goals.[9] Low-income and minority women remain at significant disadvantages with respect to access and quality of care, as well as outcomes across a broad range of conditions.

The fact that some of these issues may have seemed clearer a decade ago than they do now signals the need for continued research and education, including work on more effective ways of screening and preventing disease. It seems that these centers, while still "young," have the potential to focus on critical issues in women's health, and make important contributions in patient care. Perhaps most importantly, the CoEs can take a leadership role in translating research findings from major studies such as the Women's Health Initiative, into information and practices that can help women now. Funding, whether public or private, is often short-term, despite the desire for sustainable models and long-term impact. In this case, it may be that various forms of continued federal support could be an important bridge in the centers' abilities to make even greater contributions in women's health in the future.

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